EXHIBIT 6

PLAINTIFF FACT SHEET

PLAINTIFF'S NAME: _____

Please answer every question to the best of your knowledge. In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and accurate. If you cannot recall all of the details requested, please provide as much information as you can. For each question where the space provided does not allow for a complete answer, attach as many additional sheets of paper as necessary to fully answer the question.

I. CASE INFORMATION

A. Case caption and number: _____

B. Court in which action is pending: _____

C. Plaintiff's primary attorney and/or law firm: _____

D. Plaintiff's attorney's contact email: _____

E. If you are completing this form in a representative capacity (*e.g.*, on behalf of the estate of a person or a minor), please complete the following:

1. Your name: _____
2. Name of individual or estate you are representing: _____
3. Your Social Security Number: _____
4. Maiden/other names by which you have been known: _____
5. Your Address: _____
6. What is your relationship to the person claiming to be injured? _____

NOTE: In each of the following sections, please provide information regarding the user of the medication(s) plaintiff alleges caused injury. ***Any references to "you" or "your" refer to that person.***

II. CLAIM INFORMATION

A. **Product User Information**:

1. Name: _____
2. Social Security Number: _____
3. Maiden/other names by which you have been known: _____
4. Current address (or last address, if the person you allege was injured is deceased): _____
   _____
5. Date of birth: _____

B. **Drug Usage** – Please provide the following information for the medication(s) you claim caused your injury or injuries

	Medication: _____	**Medication:** _____	**Medication:** _____
Dates of Use – Start date and date of last use for each period of use			
Dose(s) – If you took different doses, indicate the date(s) of use for each, otherwise simply indicate what dose you took			
Course of Administration – e.g., once daily, twice daily, once weekly, etc.			
Prescriber(s) – Name, address, and phone number of healthcare provider(s) who prescribed the medication or provided you samples			
Samples – Indicate if you were ever provided samples of the medication and, if so, the name of the provider and the approximate quantity of samples provided			
Weight – What was your weight at the time you started this medication?			

C. **Injury Information** – Provide the following information related to each physical injury you claim:

Injury – State each physical injury you allege	**Injury:** _____	**Injury:** _____	**Injury:** _____
Medication(s) – State the medication(s) you claim caused each injury			
Treating Physician(s) – Name and address of physician(s) responsible for treating each injury			
Date(s) of Diagnosis – Date when you were first diagnosed with each injury			
Diagnosing Physician(s) – Name and address of physician(s) who diagnosed each injury			
Dates of Treatment – List the approximate date range during which you received treatment for each injury			

1. Have you ever been hospitalized for any injury or injuries alleged above? Yes☐ No☐
If yes, please provide the following information:

Name & Address of Hospital	Nature of Treatment	Dates of Admission/Discharge

2. Have you had discussions with any physician(s) or other healthcare provider about whether your alleged injury or injuries are, or might be, related to the use of any medication, including a medication listed above in response to Question II.B? Yes☐ No☐
If yes, please provide the following information:

Name & Address of Healthcare Provider	Date of Discussion	Medication	Nature of Statement

D. **Emotional, Psychiatric, or Psychological Injuries** – Are you claiming in this case that you suffered emotional, psychiatric, or psychological injury as a result of your use of any of the drugs listed in Question II B? Yes☐ No☐
If yes, please describe: _____

If yes, please list any health care provider(s) from whom you have sought treatment for these alleged injuries, including their name and address: _____

E. **Lost Earnings** – Do you claim or expect to claim you lost earnings or suffered impairment of earning capacity as a result of any physical, mental, or emotional injury you allege? Yes☐ No☐

F. **Medical Expenses** – Please list any out of pocket costs you have incurred relating to the diagnosis and/or treatment of any physical, mental, and/or emotional injury or injuries you allege:

Category and or Types of Expenses Incurred (e.g., co-pay, deductibles, prescriptions, etc.)	Approximate Amount of Out of Pocket Costs

G. **Fact Witnesses** – Please identify all persons (excluding physicians or other healthcare providers already identified herein) who you believe possess material information concerning your injury or injuries and/or your medical conditions.

Name (First and Last)	Address, City, State, and Zip Code	Relationship to You

III. MEDICAL BACKGROUND

A. Have you been diagnosed with diabetes? Yes☐ No☐

1. How old were you, and when were you diagnosed with diabetes? _____

2. What type of diabetes were you diagnosed with?

____ Type 1 (previously called insulin-dependent or juvenile onset)

____ Type 2 (previously called non-insulin dependent or adult onset)

____ Other. ***If other***, please describe: _____

3. Who first diagnosed you with diabetes? _____

B. Are you currently taking any medication(s) to treat diabetes? Yes☐ No☐
If yes, please list your current diabetes medications:_____

C. Aside from the medications listed in II.B and III.B, what other medications have you taken to treat diabetes in the last 10 years? _____
_____
_____

D. Blood group/Blood type: _____

E. Current height: _____

F. Current weight: _____

G. Weight at time of alleged injury or injuries: _____

H. Check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff (smokeless tobacco).

_____ I have never used tobacco

_____ I used tobacco in the past

Date tobacco use started: _____

Date tobacco use ceased: _____

Amount used: on average _____ per day for __ years

_____ I currently use tobacco

Date tobacco use started: _____

Amount used: on average _____ per day for __ years

_____ I have used different amounts of tobacco at different times. Please identify type(s) of tobacco, dates, and amounts used: _____

_____

_____

I. Did you drink alcohol (beer, wine, etc.) in the ten years before your alleged injury? Yes☐ No☐

If yes, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during that time:

____ drinks per week; ____ drinks per month; ___drinks per year; or

Other (describe): _____

J. Were you exposed, or do you have reason to believe you were exposed, to any pesticides, dyes, or chemicals used in metal refining at any time before your alleged injury? Yes☐ No☐

If yes, please explain: _____

K. Have you or any first- or second-degree blood relative—child, parent, brother, sister, grandparent, aunt, uncle, nephew, niece, half-sibling—ever experienced or been diagnosed with any of the conditions listed below:

(Please select YES or NO for each condition. If you do not know, please indicate the appropriate column. For each condition for which you answer YES, please identify who suffered the condition, you or a relative, and please provide the relative's relationship to you (e.g., state "uncle," "cousin," "brother," etc). Please also indicate whether the condition has resolved and if so, approximately when it resolved.)

	Condition Experienced or Diagnosed	Y	N	Do Not Know	Who Suffered Condition: You or Relative	Has the condition resolved? If so, when?
1.	**DIABETES CONDITIONS/DISEASES**					
a.	Diabetes (Type 1)					
b.	Diabetes (Type 2)					
c.	Hyperglycemia (high blood sugar)					
d.	Impaired fasting glucose/pre-diabetes					
e.	Insulin resistance					
f.	Hypoglycemia (low blood sugar)					
2.	**CHOLESTEROL/LIPID CONDITIONS**					
a.	Abnormal cholesterol, high cholesterol					
b.	Elevated triglycerides, hypercholesterolemia, hyperlipidemia					
3.	**CARDIOVASCULAR DISEASES**					
a.	Hypertension (high blood pressure)					
b.	Angina					
c.	Myocardial infarction (heart attack, silent heart attack)					
d.	Stroke					
e.	Peripheral vascular disease					
f.	TIA or transient ischemic attack					
4.	**EYE DISEASES/CONDITIONS**					
a.	Blurred vision					

	Condition Experienced or Diagnosed	Y	N	Do Not Know	Who Suffered Condition: You or Relative	Has the condition resolved? If so, when?
b.	Macular edema, retinopathy					
c.	Loss of vision, blindness					
5.	**DIGESTIVE SYSTEM, LIVER AND BILIARY TRACT DISORDERS**					
a.	Pancreatitis (acute or chronic)					
b.	Cystic tumor of the pancreas, pancreatic cystic neoplasm or pancreatic cysts					
c.	Gallstones, gallbladder sludge, cholecystitis, or any other abnormality of the gallbladder					
f.	Helicobacter pylori infection or stomach ulcers					
g.	Ulcers, heartburn, gastro-esophageal reflux disease (GERD)					
h.	Cirrhosis of the liver					
j.	Nausea or vomiting lasting more than 72 hours					
h.	Jaundice (yellowing of your skin)					
i.	Hepatitis A, Hepatitis B, or Hepatitis C (if applicable, circle what type)					
j.	Bile duct disease or bile duct neoplasm (if applicable, circle which one)					
6.	**KIDNEY DISEASE/CONDITIONS**					
a.	Kidney disease, kidney failure, renal failure					
b.	Nephropathy, albuminuria (albumin in the urine), proteinuria (protein in the urine)					
c.	Anuria (stopped making urine)					
d.	Required a renal catheter					
e.	Kidney stones					
7.	**GENETIC SYNDROMES**					
a.	Abnormal genes, gene mutation or genetic syndrome (including, but not limited to, hereditary breast and ovarian cancer syndrome (BRCA2 gene mutation); familial melanoma (p16 gene mutation); familial pancreatitis (PRSS1 gene mutation); hereditary non-polyposis colorectal cancer (HPNCC) or Lynch syndrome; familial adenomatous polyposis; Peutz-Jeghers syndrome; (STR1 gene mutation); Von Hippel-Lindau syndrome (VHL gene mutation).					
b.	Neurofibromatosis, type 1 (NF1 gene mutation)					
c.	Multiple endocrine neoplasia, type 1 (MEN1 gene mutation)					
8.	**OTHER CONDITIONS/DISEASES**					
a.	Alcoholism or alcohol abuse, drug addiction					
b.	Cancer (identify in section K.1 below what kind)					
c.	Cystic fibrosis					
d.	Obesity					
e.	Unintended weight loss					
f.	Allergic reaction to medication					
g.	Neuropathy (including diabetic neuropathy), peripheral neuropathy					
h.	Abdominal pain that lasted more than 72 hours					
i.	Gingivitis, periodontal disease					

1. If you answered "Yes" above to any conditions YOU suffered, or if you answered "Yes" above as to cancer suffered by you or a relative (question 8.b above), please provide the information requested on the next page (attach additional sheets as needed). If the condition you or a relative experienced is cancer, please indicate what type of cancer.

Condition	Date of Diagnosis	Name(s) & Address(es) of Healthcare Provider(s) Who Diagnosed and/or Treated Condition

L. Have you ever had any of the following medical tests:

Medical Test	Y	N	Do Not Know	Date	Location	Healthcare Provider Performing Test
Abdominal ultrasound (other than a pregnancy-related ultrasound)						
Endoscopic retrograde cholangiopancreatography (ERCP)						
Computerized tomography (CT) scan of any part of the abdomen						
Endoscopic ultrasound (EUS) of the pancreas, liver or biliary ducts						
Biopsy of the pancreas or liver						
Magnetic resonance imaging (MRI) of any part of the abdomen						
Percutaneous transhepatic cholangiography (PTC)						
Barium swallow or esophagorogaphy						
Angiogram of any part of the abdomen						
Tumor marker test (including CA19-9, CEA, CA-50, DU-PAN-2) or other blood test for cancer						
Genetic testing						

M. Have you ever had any abdominal or surgeries (including, but not limited to, gastric surgeries or surgery on your pancreas or gallbladder, whether laproscopic or otherwise)? Yes☐ No☐
If yes, please provide the information requested on the next page (attach additional sheets as needed):

Type of Surgery	Date	Hospital/Clinic	Surgeon – Name & Address

N. Other than medications already listed herein, please indicate whether you have taken for more than sixty (60) days any other medications, not identified in the pharmacy records that plaintiff is producing with this fact sheet, in the five (5) years prior to your diagnosis of pancreatic cancer, including but not limited to over-the-counter medications, dietary supplements, and or homeopathic or herbal preparations.

Medication	Indication/Condition	Date First Taken	Date Last Taken

IV. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Name(s), address(es), and phone number(s) of your family and/or primary care physician(s) for the last ten (10) years (if deceased, the last ten (10) years of life), including the approximate dates of care:

Name, Address & Phone No.	Conditions Treated	Dates of Care

B. Other than physicians already listed above, please identify the name(s), address(es), and phone number(s) of each physician or healthcare provider who provided you treatment for any condition in the last five (5) years (if deceased, the last five (5) years of life), including the approximate dates of treatment:

Name, Address & Phone No.	Condition(s) Treated	Dates of Care

C. Identify each hospital, clinic, or healthcare facility where you have received treatment (other than the offices of the physicians already identified herein) on an in-patient or outpatient basis for any condition, including treatment in an emergency room, during the last five (5) years (if deceased, the last five (5) years of life), including the approximate date(s) or time period (by date range) of treatment and reason(s) for treatment:

Name and Address of Facility	Reason(s) for Treatment	Date(s) or Time Period of Treatment

D. **Pharmacies** – Please provide the name(s), address(es), and phone number(s) of any pharmacy (or pharmacies) that has dispensed any medication(s) to you in the past ten (10) years (if deceased, the last ten (10) years of life):

Name & Address of Pharmacy
1.
2.
3.

V. PERSONAL INFORMATION

A. For each address at which you have resided in the last ten (10) years, please provide:

Address	Dates of Residence	Rented/Owned	All Other Residents

B. With respect to any marriage you have entered into, provide the information indicated below:

	Name of Spouse: _____	**Name of Spouse:** _____	**Name of Spouse:** _____
Date of Birth			
Occupation			
Date of Marriage			
If Applicable, Date Marriage Ended			
If Applicable, Manner of Dissolution (e.g., divorce, annulment, death)			

C. Please provide the name, date of birth, and current address of each of your children:

_____

_____

_____

D. For each school or other academic or vocational institution you have attended, beginning with high school, please provide:

Name & Address of School	**Dates Attended**	**Highest Grade/Degree Completed**

E. Have you ever served in any branch of the military? Yes☐ No☐

If yes, please identify which branch(es) and your dates of service:

1. Were you discharged for any reason relating to your health (whether physical, psychiatric or other health condition)? Yes☐ No☐

If yes, please state the condition: _____

2. Have you ever been rejected from military service for any reason relating to your health (whether physical, psychiatric or other health condition)? Yes☐ No☐
If yes, please state the condition: _____

F. Have you ever filed a worker's compensation claim? Yes☐ No☐
If yes, please state the year it was filed, where it was filed, the claim/docket number (if known), nature of injury claimed, and period of disability: _____

G. Have you ever made a social security disability claim? Yes☐ No☐
If yes, please state the year it was filed, where it was filed, the claim/docket number (if known), nature of injury claimed, and period of disability: _____

H. Have you ever made any other form of disability claim not already referenced above? Yes☐ No☐
If yes, please state the year it was filed, where it was filed, the claim/docket number (if known), nature of injury claimed, and period of disability: _____

I. For each of your employers for the last five (5) years (if deceased last five (5) years of life), please provide:

Name & Address of Employer	Dates of employment	Occupation/Job Duties	Salary or Weekly Wage (only answer if making a claim for lost earnings)

J. If you have ever had or been covered under any medical insurance policy in the last ten (10) years, list the name and address of the insurer, dates of coverage, policyholder, policy number, and group number for each such insurance policy.

Name and Address of Insurer	Policyholder	Policy & Group Numbers	Dates of coverage

VI. CERTIFICATION

I declare under penalty of perjury, subject to the laws of the State of California, that all of the information provided in this Plaintiff's Fact Sheet is complete, true, and correct, to the best of my knowledge.

_____ _____ _____
Signature Print Name Date

VII. DOCUMENTS

Please produce the following documents, to the extent that such documents are currently in your possession or in the possession of your attorneys.

A. If the plaintiff is representing a decedent's estate, the death certificate of the decedent.

B. If the plaintiff is representing a decedent's estate, documents sufficient to evidence your authority to act on behalf of the estate, including, letters of administration or court order appointing you to administer the estate.

C. If the plaintiff is acting in a representative capacity for a person who is not deceased, all documents establishing authority to act in such representative capacity.

D. All diagnostic imaging referring to or relating to the injury or injuries alleged.

E. Each informed consent form signed by you in connection with treatment by a health care professional and/or institution relating to any medication you allege to have caused any injury.

F. All documents, including but not limited to literature and/or warnings, received by you from any source relating to any medication you allege to have caused any injury.

G. All documents referring or relating to your medical history, including but not limited to medical records.

H. Report of autopsy of decedent (if applicable).

I. All documents referring or relating to your use of the medication(s) you allege to have caused any injury, including but not limited to pharmacy records or receipts.

J. All documents relating to your insurance coverage that is/are applicable to the illness, injury, or medical condition which forms the basis of your complaint, including any application to any insurer for coverage, whether insurance was obtained or not.

K. If you claim that you have suffered physical, mental and/or emotional injuries as the result of the use of any medication, all documents submitted to or received from the Social Security Administration, any workers' compensation agency, or any disability insurer concerning any disability claim you have made related to said injury or injuries.

L. All press releases or other public statements made by you or any other person, whether or not acting at your direction, relating to this litigation or to your illness, injury, or medical condition that forms the basis of your complaint.

M. To the extent not provided in responses to requests A to L above, all documents referring to or relating to your alleged injury or any claimed damages, including, but not limited to, medical bills, correspondence, notes, and journals.

VIII. AUTHORIZATIONS

Please provide the attached Authorizations for release of records as specified in the Order of the Court adopting this Plaintiff Fact Sheet. Authorizations shall be completed and signed without setting forth the identity of the custodian of the records or provider of care. If you are signing in a representative capacity or on behalf of a decedent, please provide documents evidencing your authority to sign these authorizations, if any. If you are signing on behalf of a decedent, please also provide a copy of the death certificate.